

Food and Drug Administration  
Center for Food Safety and Applied Nutrition  
Office of Special Nutritionals

ARMS#

13167



8 - OTHER

**000001**

IEC NO	FIC	COMMERCIAL	SERVICE	TYPE	ROOM NO
PATIENT INFORMATION			MEDICAL IN	PATIENT	
SOC SEC NO			ADMITTING PHYSICIAN	ARRIVE	
MARITAL STATUS			ADMITTED BY	DISCHG	
RELIGION			DATE		
DATE OF BIRTH			TIME		
PLACE OF BIRTH			09/09/98		
FATHER'S NAME			16:08:00		
ADMITTING DIAGNOSIS			LENGTH OF STAY		
ADMITTING PHYSICIAN			DAYS		
RESPONSIBLE FOR BILL			PATIENT OCCUPATION/EMPLOYER & ADDRESS		
NO			NOTIFY IN CASE OF EMERGENCY:		
SPOUSE			RELATIONSHIP		
SPOUSE EMPL.			PHONE NO.		
PHONE NO			SUBSCRIBER		
IF INSURANCE CO			POLICY NO.		
GROUP NO.			SUBSCRIBER		
POLICY NO			GROUP NO.		
SUBSCRIBER			POLICY NO		
GROUP NO.			SUBSCRIBER		
F INSURANCE CO			POLICY NO		
GROUP NO.			SUBSCRIBER		
MEDICARE NO			EFFECTIVE DATE		
MEDICAID NO.			ADDITIONAL COMMENTS		

DIAGNOSIS	CODE#
<p>① Hypothyroidism</p> <p>② Hypertensive Crisis</p> <p>③ Morbid Obesity</p> <p>④ Acute Sinusitis</p>	
ADDITIONAL DIAGNOSIS	
MAJOR PROCEDURES	
<p>None</p> <p>Adverse Event Project # 13167</p> <p>3/26/99 HRB</p> <p>Exhibit # 2 Pg 9 of 34</p>	

CAUSE OF DEATH	DISCHARGE STATUS
	<input type="checkbox"/> 01 DIS. TO HOME <input type="checkbox"/> 02 DIS. TO ANOTHER HOSPITAL <input type="checkbox"/> 03 DIS. TO SNF <input type="checkbox"/> 04 DIS. TO ICF <input type="checkbox"/> 05 DIS. TO ANOTHER TYPE FACILITY <input type="checkbox"/> 06 DIS. TO HOME HEALTH CARE <input type="checkbox"/> 07 AMA <input type="checkbox"/> 20 EXPIRED

000002

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge

CHART COPY

SIGNATURE OF ATTENDING PHYSICIAN

DATE